

The mushroom was then brought to the Mushroom Research Centre in University of Malaya for expert identification and subsequently was identified as *Chlorophyllum Molybdites* which could cause GI gastrointestinal disturbance.

All patients were discharged well after 3 days without any complications as symptoms improved and blood investigation failed to reveal any organ dysfunction/ residual toxicity.

## DISCUSSION

This is a case series depicting the effect of mushroom poisoning in a family. The series also showed that the symptoms were proportionate to the quantity ingested.

## CONCLUSION

Mushroom poisoning should be included as one of the differential diagnosis in cases of gastroenteritis after ingestion of mushroom. On any event of mushroom ingestion presenting with AGE symptoms. Early identification of the mushroom identification will be helpful in assisting the predicting patient outcome including management plan. Early anticipation in form of guided fluid resuscitation are compulsory is necessary to prevent dehydration and further deterioration of patient condition.

We presenting case series of a family with mushroom poisoning. We are first in world to present such case which patient ingest same type mushroom

with different outcome- proportionate to quantity ingested.

We are also first in world to report same type of mushroom poisoning with outcome (Quantity based) from different age group/population (Adult /Pregnant Lady/Pediatric/Geriatric) group.

## **OP 3 A PROSPECTIVE OBSERVATIONAL STUDY ON THE IMPACT OF A PROTOCOL-DRIVEN MANAGEMENT OF ST ELEVATION MYOCARDIAL INFARCTION (STEMI) ON EVENT TIMINGS IN A NEWLY-ESTABLISHED STEMI NETWORK**

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## INTRODUCTION

The network was a collaboration between an Emergency Department of a non-capable percutaneous coronary intervention (PCI) centre and a PCI-able centre to enable access for ST elevation Myocardial Infarction (STEMI) patients for Primary Percutaneous Coronary Intervention (PPCI). The aim of the study is to determine if a protocol driven management of STEMI patient will improve the first medical contact

(FMC) to balloon time with this network.

## **METHODS**

All STEMI patients had a focused history, examination and ECG performed. A standardized form was filled and the patients were managed as per local guidelines. Symptom onset to ED, door-in-door-out time (DIDO), PCI centre door-to-balloon time (D2B), first –medical-contact (FMC) to balloon and total ischemic time were collected. In-hospital and 30-day mortality rate at 30 days were also reported. The data derived were divided into two phases. This is to evaluate temporal improvements as the network matures.

## **RESULTS**

150 patients were enrolled in the 13 month period (n=46 for phase A and n=104 for phase B). The DIDO for the first cohort was 44 minutes, IQR (30-72) and this timing reduced significantly in the second cohort (30 minutes, IQR (24.5-50),  $P=0.043$ ). The median FMC to balloon times also reduced significantly between the 2 phases (phase A, 111.5 minutes, IQR (95.75-132.75) and phase B 88 minutes IQR (75-108).  $p<0.001$ ). There was no difference between in-hospital deaths reported between the phases (8.7% vs 2.9%.  $P=0.202$ ). Thirty-day mortality differences were also not significant (2.4% vs 2.0%,  $P=0.971$ ).

## **CONCLUSION**

A protocol-driven management of STEMI patients could improve system timings like the DIDO and the FMC to balloon times as the network “matures” with time. There were no significant differences observed in the in hospital death and 30-day mortality rate. Further study is required to

evaluate the long term impact over of this strategy.

## **OP 4 ARE ALL EVENT MEDICAL COVERAGE SERVICES EQUAL? A CASE SERIES FROM A FRIENDLY GAME OF RUGBY**

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## **INTRODUCTION**

Event medical coverage is an integral part of pre-hospital care medicine and is increasingly used by event organisers to mitigate risk of high risk events such as contact sports and mass gatherings. Rugby is a collision sport played by amateurs and professionals. The game is physically demanding and results in a high incidence of injury, reportedly up to 497.6 events per 1000 playing hours.

## **CASE SERIES**

We report on an event medical coverage for a rugby tournament which pitted 13 teams against each other with a total of 192 players, 46 team staff and 15 referees. During the 2-day event, there were a total of 26 players requiring medical attention. 2 required hospital referrals. The overall incidence of injury was 302.94 per 1000 playing hours. Two players who were originally discharged by the medical team subsequently presented to the hospital with deterioration of their condition.